Customer Web Portal Account Request Form

Please complete all of Sections I, II, and III.

I. Provider/Submitter Information*

(*Section can be completed by group practice organization or billing intermediary)

Enter contact information for the provider/submitter for whom account management access is requested.

First Name	Last Name	Title	E-mail

DBA Name:	Provider/Submitter No.	Phone No.

Street	City	State	Zip

II. Type of Request

Check the appropriate box to indicate the reason for completing and submitting this form.

☐ New User(s) ☐ Add User(s) ☐ Change User(s) Access ☐ Deactivate User(s)

III. User Information

List all persons that should be granted access to the provider/submitter's account. Also specify the access type for each user. Once the account is created, a username and password will be sent in two separate e-mails to each user listed below. **PT-1 gives the user the option to complete and submit Prescription for Transportation requests, and Publications allows the user to order MassHealth publications through the online tool.*

First Name	Last Name	E-mail	Provider No.	Title	Access Type	
					PT-1	Publications
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

You will be contacted by MassHealth once your request has been completed. No further action is required from you.